UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

CYCLOSET

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX THIS COMPLETED FORM TO 855-828-4992

CRITERIA FOR CYCLOSET:

- Age > 18 years.
- Diagnosis of Type 2 Diabetes.
- Failure on or contraindication to Metformin.
- May not be used concurrently with a TZD (i.e. Avandia or Actos) or by lactating women.
- Maximum approved dose is 4.8mg daily.

Initial authorization is for 6 months – renewal periods of 1 year require documentation of improvement of A1C and/or fasting plasma glucose.

NOTES:

This form is for Non-Traditional clients (blue card) only. Traditional clients (purple card) may receive this medication without a Prior Authorization.

AUTHORIZATION:

1 year.

RE-AUTHORIZATION:

Updated letter of medical necessity

8/4/10